

ANNUAL PHYSICAL EXAMINATION FORM

Massachusetts Department of Mental Retardation

Name:					Date:		
Vital Signs:	Ht	Wt	T°	BP	P	R	
General Appearance:							
Skin:							
HEENT:							
Head							
Eyes/Vision Screen							
Ears/Hearing Screen							
Mouth/Throat							
Neck:							
Chest:							
Breast:							
Heart:							
Lungs:							
Abdomen:							
Genitalia:							
GYN/Testicular Exam							
Rectum:							
Musculoskeletal:							
Back/Spine							
Extremities							
Lymph Nodes:							
Circulatory:							
Neurologic:							
Cranial Nerves							
Reflexes							
Sensory							
Motor							
Cognitive							
Other:							

HC Provider Signature: _____